CASE MANAGEMENT TEAM NAME
ADDRESS
PHONE NUMBER FAX NUMBER

HCBS REFERRAL FOR SERVICES

HCBS Referral ☐ HCBS Amendment ☐

This is to notify you that the consumer named below has chosen Home and Community Based Services from your agency.

Provider: _____ Provider No: _____

Recipient Name: _____ Phone No: _____

Address: _____

Physician: _____ Phone No: _____

Medicaid ID No: _____ Date of Birth: _____

Primary Diagnosis: _____ Diagnosis Code: _____

PA No. _____ Date Span: _____

Service	Procedure Code	Mod	Current Units/Dollars	Corrected Units/Dollars	Effective Date
		UA			
		UA			
		UA			
		UA			
		UA			
		UA			

Comments:

_____ _____ _____
Case Management Team Signature Phone Date